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AN INTERNATIONAL COMPARISON OF HEALTH-CARE SYSTEMS

Harvard Community Health Plan Annual Report 1992

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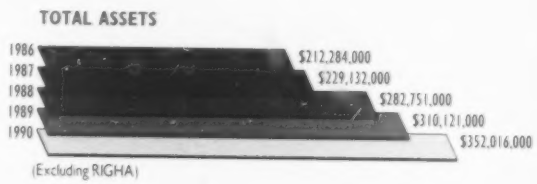
COMPARING HEALTH-CARE SYSTEMS

The U.S. is currently debating whether we should introduce universal health coverage and about how our medical-care delivery system may be improved. We believe that these are separate issues. The first involves health-care financing; providing coverage to all Americans would be socially desirable; how to change the medical-care delivery system (to improve its efficiency and quality) is a different issue, and it opens up a wide range of alternatives. I believe the U.S. could provide universal access *and* bring our costs under control if a coherent program of entitlement and delivery-system reform were adopted.

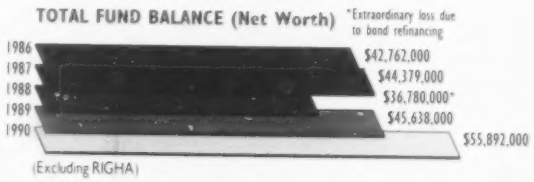
We believe that exposing the public to how other major health-care systems function can make an important contribution to the debate. For this reason, we have commissioned an unusual six-country survey by Louis Harris and Associates.



As you will note, the survey finds Americans much more satisfied with their health care than is often supposed. We believe that, while much of this overall satisfaction is justified, much is unwarranted.

The survey reveals substantial gaps in satisfaction between the rich and the poor, the insured and the uninsured, that are unique to the American health-care system. Our system provides excellent technology, but too much technology is used without purpose and without evaluation. Our infant mortality and life expectancy indices are worse than in countries that spend much less on health care.

We know that inefficiency has been built into the very core of our health-care system, through third-party reimbursement, almost absolute freedom of choice for patients (with the high, often unrealistic, expectations it creates), and a resistance to tight management that is grounded in professional traditions and preferences.



It will probably surprise no one that we believe American health care (including at Harvard Community Health Plan) costs too much, and we are working constantly to bring those costs down. Medical care can no longer afford inefficiency; its costs threaten other social priorities, such as education and housing, and undermine our ability to extend care to everyone. We are convinced that excellence, or quality, can go hand-in-hand with efficiency. Such a link appears to exist in other countries; they are doing better than we do, and for less.

The results of this survey (and the essays that follow) do not lead us to endorse any one of the health-care systems studied. We simply hope it will challenge and inform those people who will decide on the future of the U.S. health-care system.

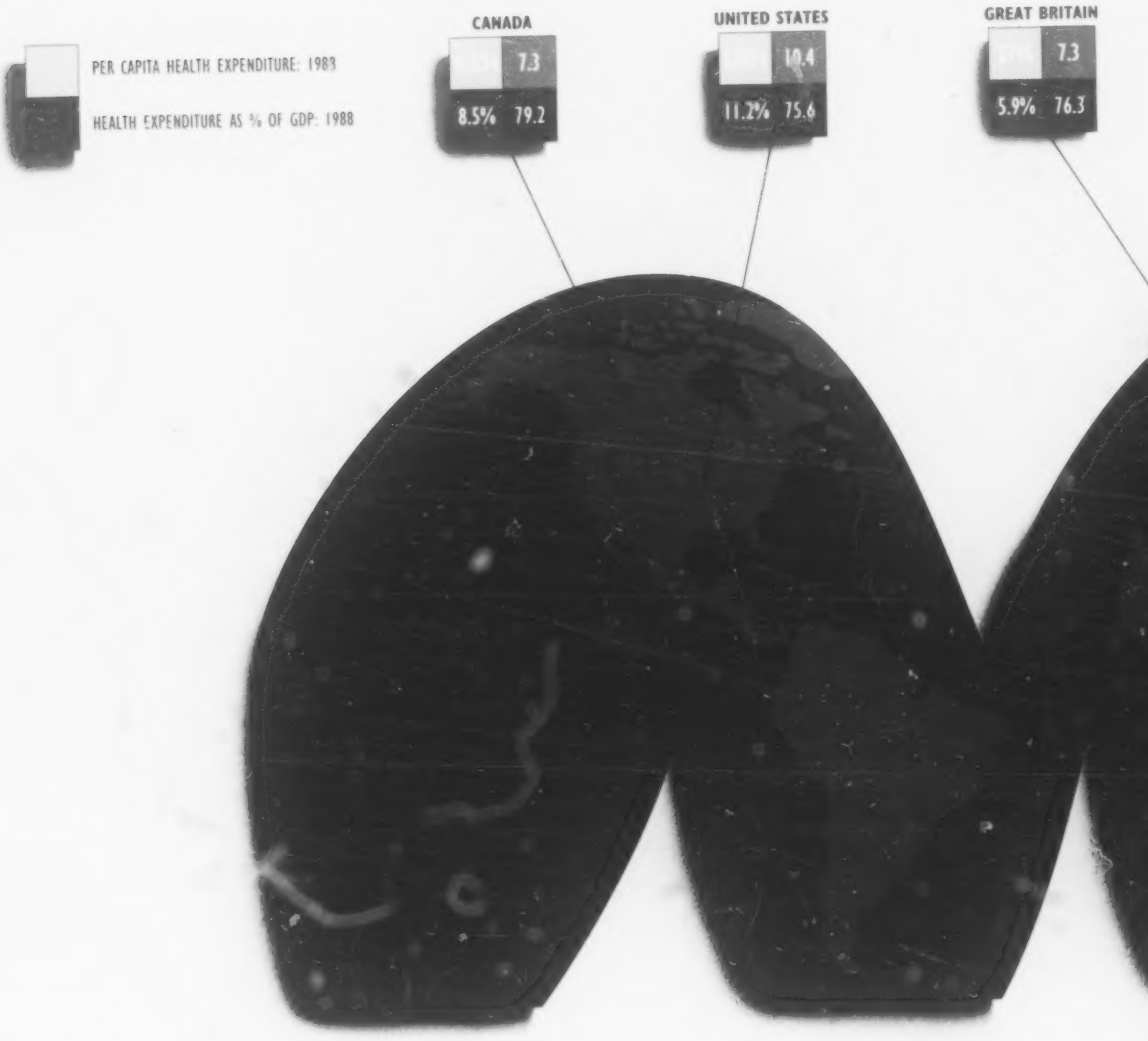
Thomas O. Pyle
Chief Executive Officer and
Chairman-elect of the Board

COMPARING HEALTH-CARE SYSTEMS

In what countries do health-care systems generally work well? Where do acceptable costs deliver acceptable outcomes? What countries provide the best relative health-care value to their citizens (that is, the best balance of cost and quality)? And, if other countries have devised better ways to pay for and deliver health care, which of these approaches might be transportable to the United States?

This report intends to address those questions by comparing the health-care systems of six industrialized countries: Canada, (Western) Germany, Great Britain, Japan, Sweden and the United States.

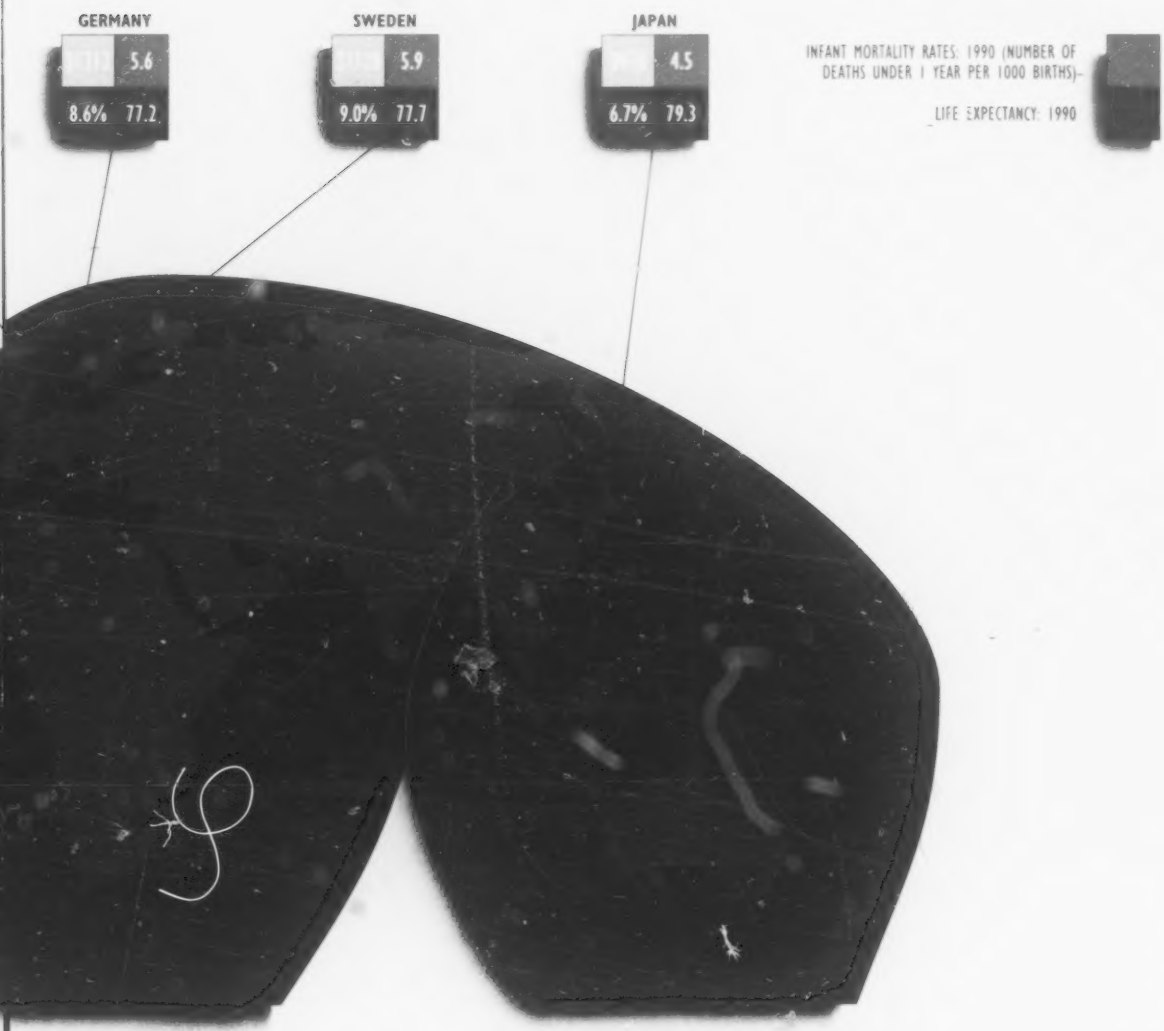
Of the six countries compared, only the U.S. lacks a system of universal health-care coverage for all its citizens. The U.S. mix of private and public coverage leaves about 33 million people uninsured, although some of those have access to state or local "charity care" or



"free care." Each of the other countries has compulsory public insurance combined with optional supplemental private insurance, or, in the case of Germany, a mix of compulsory public and private insurance by which all citizens are covered.

The differences in health-care costs among the six countries are striking. Per-capita spending in the United States is 170 percent higher than in Great Britain, and 63 percent above the six-country average. Furthermore, when national outlays are calculated as a percentage of Gross Domestic Product, the U.S. spends almost 25 percent more on health care than Sweden, which devotes the next-highest fraction of national GDP to this purpose.

The quality of health care each country receives for its money is difficult to gauge. As leading health-service researchers have demonstrated (HCHP Annual Report, FY89), any attempt t measure the performance of health systems, even within a single country, faces



considerable difficulties in defining and measuring *what is appropriate* and *what works* in health care. Until we become more adept at measuring outcomes, only aggregate measures of health such as infant mortality and life expectancy can be compared across countries.

While there is no absolutely "correct" level of expenditure for health care, a reasonable person might hope that greater expenditure would lead to better medical care and better outcomes. However, that does not appear to be the case: Of the six countries surveyed, the U.S. has the lowest average immunization rate for dyptheria, measles and polio among children under the age of one; Sweden has the highest rate. The Japanese (who spend next to the least on health care) have the most favorable rate of infant mortality and the longest life expectancy; Americans (who spend the most) have the worst rates in both these categories.

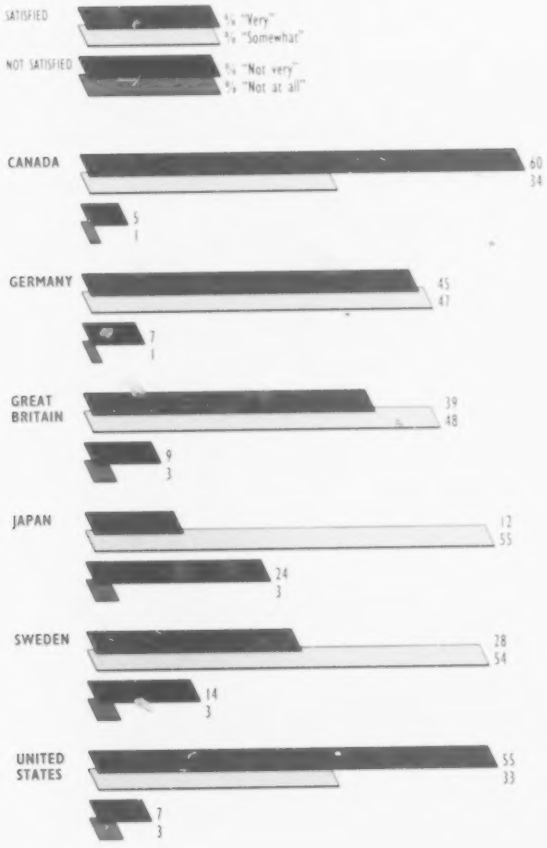
Since environmental and lifestyle factors can influence life expectancy and infant mortality as much as the health-care system can, these two measures are only partial indicators of national health-care quality. Health-care quality must be measured as well in terms of consumer expectations and satisfaction.

The Louis Harris survey conducted for this report measured overall consumer satisfaction with the health care available in each of the six countries. It also measured the importance consumers attached to seven separate "dimensions," or attributes, of quality in health care and their satisfaction with each:

- receiving health care of the best possible quality;
- having enough personal control over medical decisions;
- being able to get elective surgery without delay;
- not having to wait too long for a doctor's appointment;
- having available the latest medical technology;
- minimizing personal out-of-pocket costs for health care; and
- offering everyone the opportunity to receive top-quality care regardless of income.

OVERALL SATISFACTION

Q.: Overall, how satisfied would you say you are with the health care available to you and members of your household?



The survey also measured the perceived appropriateness of health-care spending, and whether people perceived that they had ever been unable to get needed care.

Using the available data on national spending, health measures and consumer satisfaction, our comparison provides a framework for judging the overall performance of the health-care systems examined.

A more detailed, country-by-country look at the data on consumer attitudes is presented in the next section of this report. Taken together with the data on spending and health measures, the Harris survey data on importance and satisfaction yield some key conclusions:

- While there is no indication that a higher level of national health-care spending results in better outcomes, personal satisfaction with many aspects of care is highest in the two countries with the highest per-capita spending: Canada and the U.S..
- In terms of importance, the opportunity for everyone to receive top-quality care, regardless of income, is the number-one priority in all six countries. Yet people's desires for equal care are not being satisfied; it is the only aspect of health care for which the satisfaction ratings are lower than the importance ratings in every country. In fact, the deficit between importance ("absolutely essential") and satisfaction ("very satisfied") averages almost 20 percentage points per country.
- Universal coverage, which is found in every country surveyed except the United States, does not guarantee high levels of satisfaction in either the opportunity for everyone to receive high-quality care, as indicated above, or in minimizing personal out-of-pocket costs for health care. Satisfaction with out-of-pocket costs was less than 50 percent in every country except Canada.
- The most striking difference in satisfaction levels between the U.S. and the other five countries was found in being able to get elective surgery promptly; half of Americans surveyed were very satisfied, while less than a third of the respondents in each of the other five countries were very satisfied.

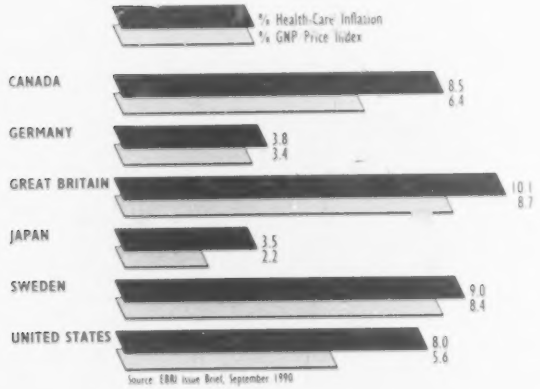
PERCENTAGE OF 1 YEAR OLDS FULLY IMMUNIZED

	DIPTHERIA	MEASLES	POLIO	AVERAGE
CANADA	85%	85%	85%	85%
GERMANY	97%	50%	95%	81%
GREAT BRITAIN	70%	76%	87%	78%
JAPAN	83%	73%	95%	84%
SWEDEN	99%	93%	98%	97%
UNITED STATES	37%	82%	92%	70%

Source: United Nations Children's Fund (UNICEF), The State of the World's Children 1990.

HEALTH-CARE INFLATION VS. GENERAL INFLATION

Compound Annual Growth Rates 1977-1987



Source: EBRI Issue Brief, September 1990

- Of the health-care dimensions surveyed, respondents seem most content overall with their waiting times for making a doctor's appointment; satisfaction in this category exceeds importance by an average of 11 percentage points among the six countries.
- With respect to key demographic subgroups, overall satisfaction with health services is highest in all six countries among people age 50 or older. In all the countries surveyed, men and women tend to be equally satisfied with health services.
- In five of the countries, overall satisfaction among those in the lowest third of the income distribution is virtually identical to satisfaction for the entire population. The exception is the United States, where the poorest third of the population is significantly less satisfied with health services than Americans overall (45 percent vs 55 percent "very satisfied"). And uninsured Americans are much less satisfied overall than the insured (29 percent vs 57 percent "very satisfied").

Given these results, we in America face an interesting dilemma. Our system fares poorly in terms of cost, universal access and outcomes, yet satisfaction remains relatively high. Can we, therefore, "fix" our cost and universal access problems without reducing satisfaction in (politically) unacceptable ways?

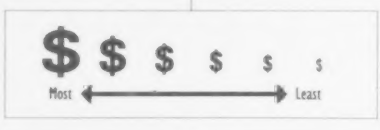
Decision-makers in the other five countries face a different set of questions: Is there an unacceptably low level of satisfaction with some aspects of health-care delivery with their current system? Why, despite universal coverage, is satisfaction with the opportunity for everyone to receive top-quality care so low? Can satisfaction be increased without also increasing health-care inflation? Or have they achieved a reasonable balance among cost, quality and access?

Our report concludes with the views of several leading health-care experts on how U.S. decision-makers might make the best use of what we know about the health-care systems of other countries. While there are undoubtedly lessons to be learned from each of the countries surveyed, their essays focus the debate, not surprisingly, on our neighbor, Canada.

RATING HEALTH-CARE VALUE: IS ONE SYSTEM BEST?

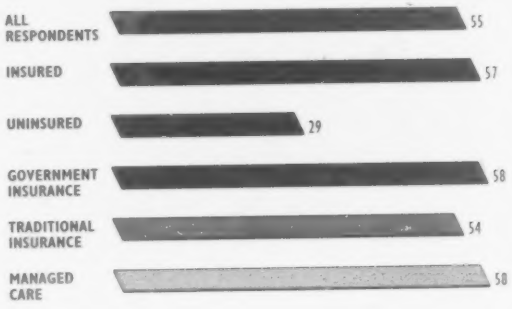
A Summary of the Satisfaction, Spending, and Health Data Found in this Report.

		NATIONAL SPENDING	
		$ PER CAPITA	$ AS % OF GDP
CANADA	Compulsory public insurance Widespread supplementary private insurance	$	$
GERMANY	Compulsory public or private insurance	$	$
GREAT BRITAIN	Compulsory public insurance Limited supplementary private insurance	$	$
JAPAN	Compulsory public insurance Limited supplementary private insurance	$	$
SWEDEN	Compulsory public insurance Limited supplementary private insurance	$	$
UNITED STATES	Voluntary private insurance 13% uninsured Public insurance for the poor (comprehensive) and elderly (limited)	$	$



SATISFACTION IN U.S. BY TYPE OF INSURANCE

Percent "very satisfied," overall, with the health care available to them and their families.



KEY TO SATISFACTION RATING

Technology:
Being able to get the most advanced tests, drugs, medical procedures, and equipment

Control:
Having enough personal control over decisions affecting your own medical care

Quality:
Receiving health care of the best possible quality

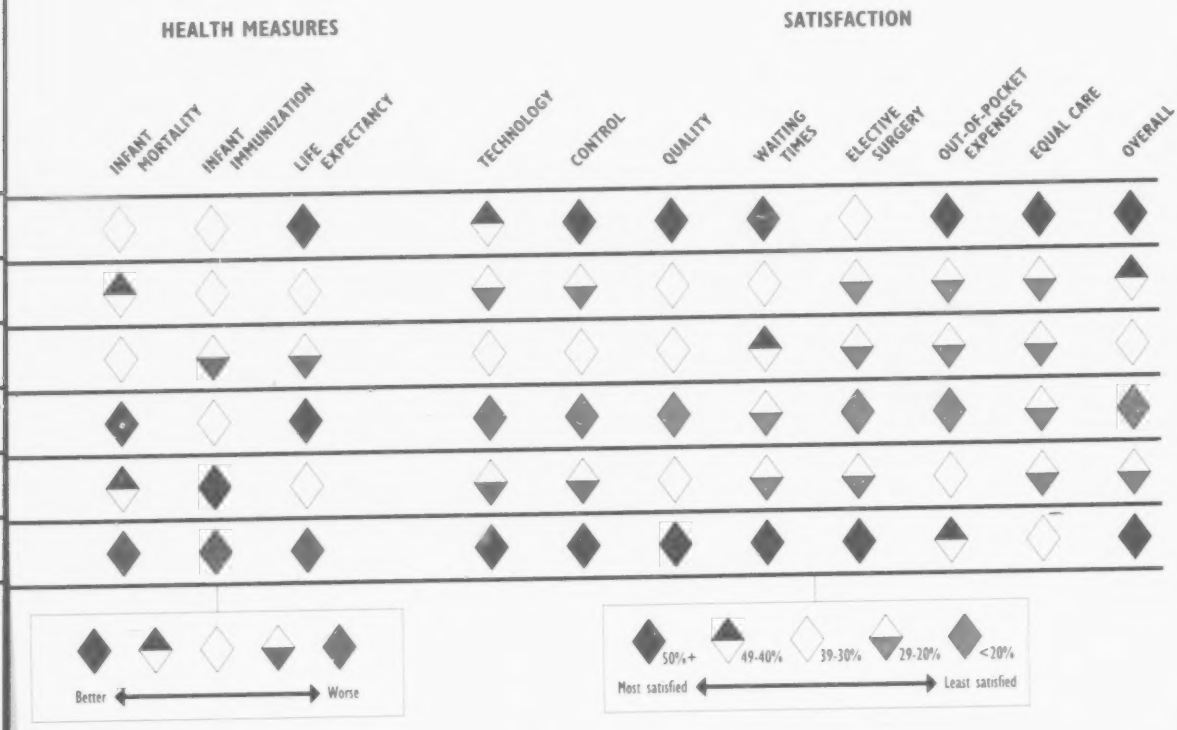
Waiting Times:
Not having to wait too long to get an appointment to see the doctor once you call

Elective Surgery:
Being able to get *elective* surgery—that's surgery for conditions that aren't immediately life-threatening—promptly without much delay

Out-of-Pocket Expenses:
Minimizing your personal out-of-pocket costs for health care

Equal Care:
The opportunity for everyone to receive top-quality health care regardless of their income

Overall:
Overall satisfaction with the health care available to you and members of your household



CANADA

Among the six countries surveyed, Canada's health-care services get the best overall marks from its citizens. Canadians are especially satisfied with quality, personal control, not having to wait too long to see a doctor, and minimizing the personal costs of care.

Canadians are significantly less satisfied with their access to high-technology medicine and to elective surgery, although their satisfaction levels in these categories are still relatively high compared with most of the other countries surveyed.

The opportunity for everyone to receive top-quality care is the only attribute for which the percentage of "very satisfied" responses falls below the percentage of "absolutely essential" responses; while Canadians rate equal care the single most important aspect of health care, they rank it only the fifth most satisfactory. Even so, the percentage of people very satisfied with equal care in Canada is much higher than in any of the other countries. Among the populations surveyed, Canadians are the most likely to feel they are unable to see a specialist in a timely fashion or unable to get all the diagnostic tests they need.

By a narrow plurality, Canadians feel the amount of money being spent on health care is about right in all four categories.

PERCENTAGE OF POPULATION WITH PUBLIC COVERAGE:
100%.

ELIGIBILITY:
Automatic for all residents.

WHAT'S COVERED:
Hospital care: 100%.
Outpatient care: 100%.
Prescription drugs: varies by province. In all provinces, 100% for elderly.

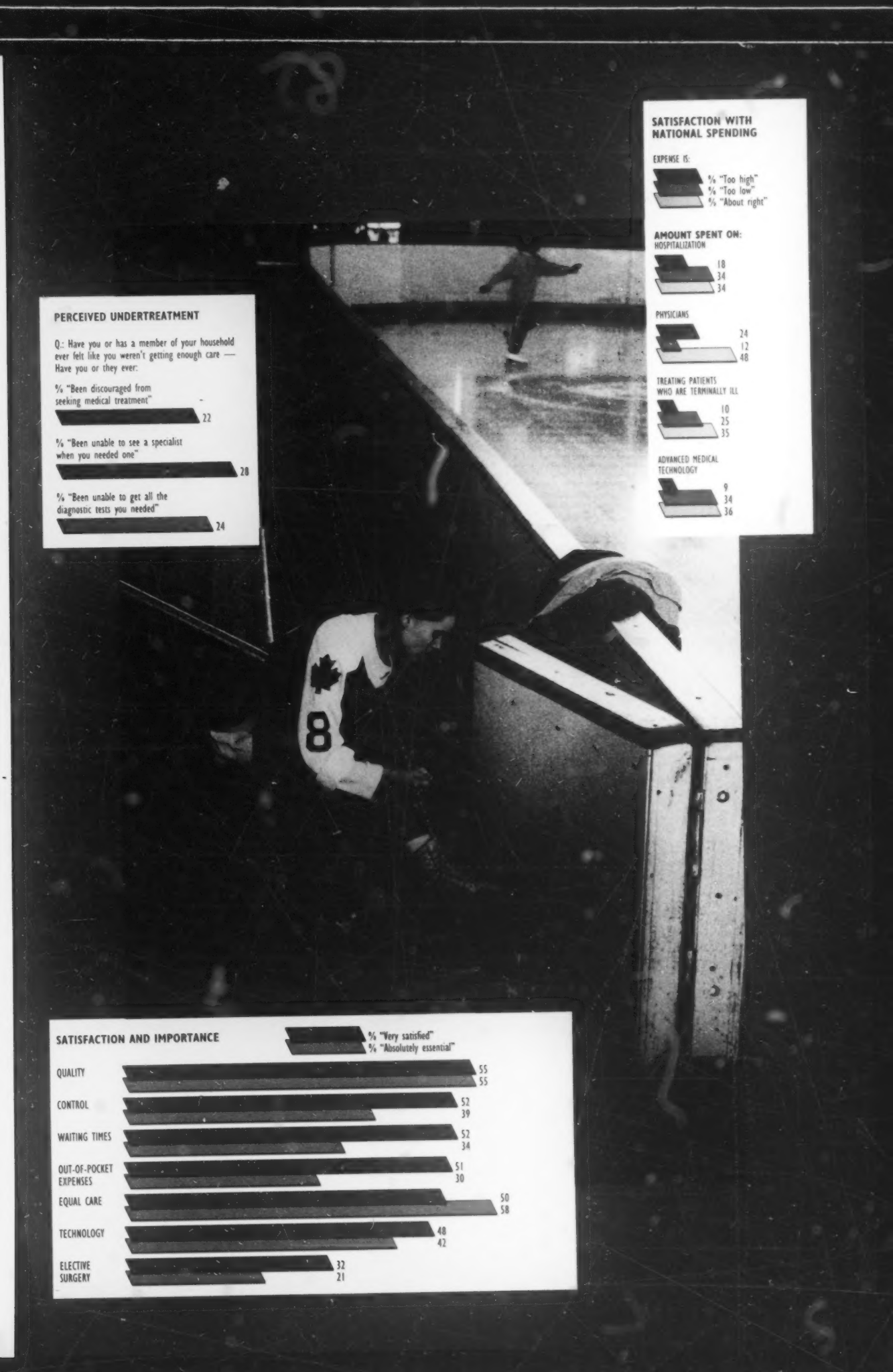
HOW FINANCED:
38% by national taxation, 62% by provincial taxation.

DELIVERY SYSTEM:
Private physicians in fee-for-service practices who bill Provincial Health Ministries monthly for services provided; in five provinces, physician fees are governed by expenditure targets.
Trustee- or community-owned hospitals that negotiate an annual prospective budget with the provincial government; capital expenses are covered through provincial capital budgets.

PERCENTAGE OF POPULATION WITH PRIVATE COVERAGE:
90% have supplementary coverage.

SOURCE OF PRIVATE INSURANCE:
Employers, who may pay from 50 to 100%.

NOTE:
Provinces prohibit private insurance from covering anything that is already covered by public insurance, so private insurance typically covers "extras" like private hospital rooms, prescription drugs, ambulance service, and nursing-home care.


PERCEIVED UNDERTREATMENT
Q.: Have you or has a member of your household ever felt like you weren't getting enough care — Have you or they ever:
% "Been discouraged from seeking medical treatment"
22
% "Been unable to see a specialist when you needed one"
28
% "Been unable to get all the diagnostic tests you needed"
24
SATISFACTION WITH NATIONAL SPENDING
EXPENSE IS:
% "Too high"
% "Too low"
% "About right"
AMOUNT SPENT ON:
HOSPITALIZATION
18
34
34
PHYSICIANS
24
12
48
TREATING PATIENTS WHO ARE TERMINALLY ILL
10
25
35
ADVANCED MEDICAL TECHNOLOGY
9
34
36
SATISFACTION AND IMPORTANCE
% "Very satisfied"
% "Absolutely essential"
QUALITY
55
55
CONTROL
52
39
WAITING TIMES
52
34
OUT-OF-POCKET EXPENSES
51
30
EQUAL CARE
50
58
TECHNOLOGY
48
42
ELECTIVE SURGERY
32
21

GERMANY

Overall, (West) Germans' satisfaction with their health services trails that of Canadians, but is higher than in the U.S., Britain, Sweden or Japan. Regarding the various aspects of their health-care system, Germans rank fourth among the six countries surveyed on every question except the ability to get elective surgery without delay, where they rank fifth, ahead of Japan.

Germans rank their own satisfaction highest with the waiting time to schedule an appointment with a physician and with receiving what they consider to be high-quality care. They are least satisfied with their access to elective surgery and with their ability to keep their personal costs of care to a minimum. The area in which the disparity between high importance and low satisfaction is greatest is on the question of equal care regardless of income.

Among the six surveyed populations, Germans appear to be the most content with their nation's health-care spending. Solid pluralities feel that spending for hospitalization, physicians and advanced medical technology is "about right."

PERCENTAGE OF POPULATION WITH PUBLIC COVERAGE:
90%.

ELIGIBILITY:
All residents (mandatory for employees earning less than $33,000/year).

WHAT'S COVERED:
Hospital care: 100%, with a small daily copayment for the first two weeks.
Outpatient care: 100%.
Prescription drugs: 100%, with a $2 copayment per prescription.

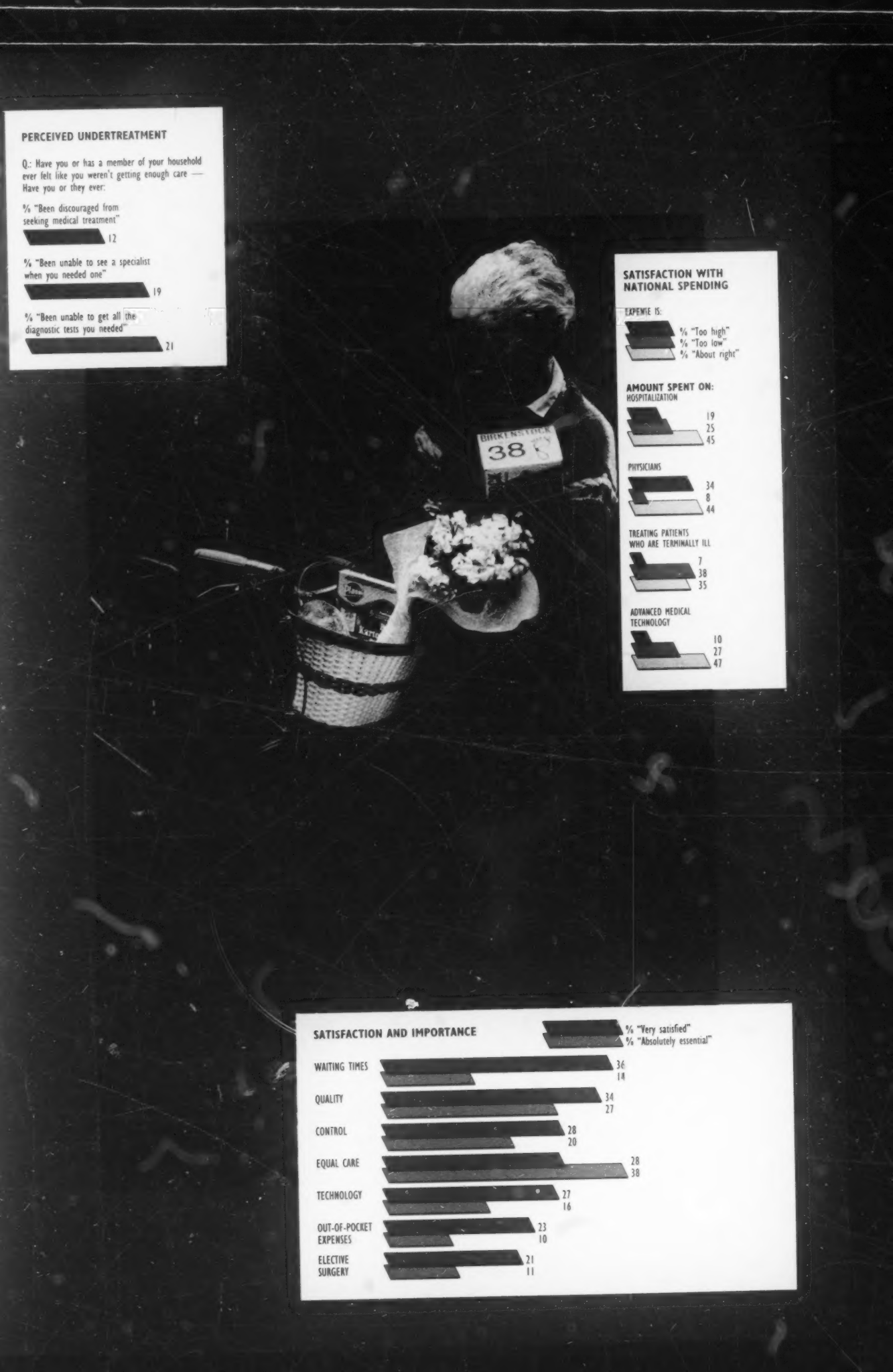
HOW FINANCED:
Decentralized "sickness funds" are financed through payroll taxes, with equal contributions by employees and employers; also a 6.5% tax on social security pensions plus an income-based tax on private pensions for retirees. Unemployed, disabled, elderly and poor are covered under social security.

DELIVERY SYSTEM:
Outpatient physicians are paid on a fee-for-service basis through sickness-fund associations which they must join; fees are governed by overall expenditure targets; hospital physicians are salaried.
Sickness funds reimburse hospitals, which are community- or individually-owned, for operating costs. Capital costs are covered by state governments.

PERCENTAGE OF POPULATION WITH PRIVATE COVERAGE:
8% have primary private coverage; 7% have secondary private coverage (supplemental to public).

SOURCE OF PRIVATE INSURANCE FINANCING:
Primary: 50% employer, 50% employee.
Secondary: 100% employer.

NOTE:
Germans who earn more than $33,000/year can opt out of public insurance for private coverage. However, once this choice is made, they cannot rejoin the public plan.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23
10
ELECTIVE SURGERY
21
11

GREAT BRITAIN

Great Britain's health system provides moderate overall satisfaction levels—above those of Japan and Sweden but below those of Germany, the U.S. and Canada. Among the categories surveyed, the British rank their own satisfaction highest with not having to wait too long to see a doctor and receiving high-quality care. In Great Britain, as in the U.S. (not withstanding the great differences in universal coverage), those surveyed are least satisfied with their system's success in providing everyone the opportunity to receive top-quality care.

Nearly three-quarters of British respondents feel that spending on hospitals is too low. In addition, a majority feels that expenditures for advanced medical technologies and treating the terminally ill are too low, and a plurality feels that spending on physicians is too low.

While they enjoy the lowest per-capita health-care spending of the six populations surveyed, the British are less inclined to feel that they've been denied needed care than the respondents in all other countries except Sweden.

PERCENTAGE OF POPULATION WITH PUBLIC COVERAGE:
100%.

ELIGIBILITY:
Automatic for all residents.

WHAT'S COVERED:
Hospital care: 100%.
Outpatient care: 100%.
Prescription drugs: 100%, with nominal copayment per prescription.

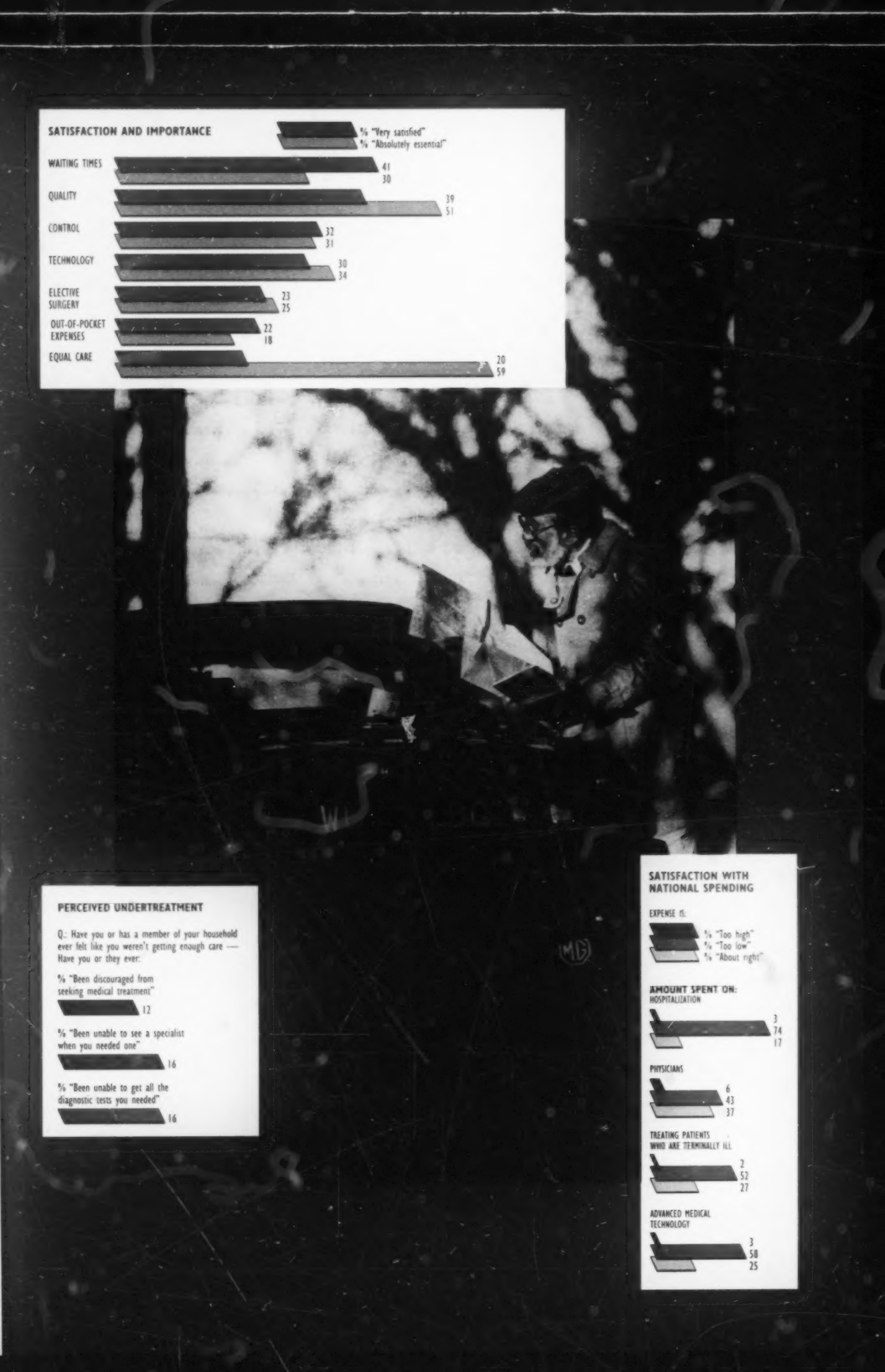
HOW FINANCED:
85% by general taxation through the National Health Service (NHS); 15% by employer and employee contributions to the National Insurance Fund.

DELIVERY SYSTEM:
Outpatient physicians are reimbursed through a combination of capitation and negotiated and binding fees; hospital physicians are salaried. NHS-owned hospitals receive an annual prospective budget.

PERCENTAGE OF POPULATION WITH PRIVATE COVERAGE:
9% have supplementary coverage that is often used to cover elective surgery and to avoid NHS waiting lists.

SOURCE OF PRIVATE INSURANCE:
Employers, who may pay from 0–100%.

NOTE:
The NHS is currently undergoing some significant changes as a result of the 1989 adoption of a White Paper on health-care reform. The White Paper strengthens competitive elements within the NHS by allowing hospitals to become self-governing trusts that compete for patients, and by giving general practitioners with over 11,000 patients a fixed amount of money to purchase hospital services previously provided free by the NHS.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3
58
25

JAPAN

Overall satisfaction with the delivery of health care in Japan is lower than in any of the other countries studied. In fact, more than a quarter of Japanese respondents say they are dissatisfied with their health services—nearly three times the dissatisfaction level in the U.S.

Among the various categories surveyed, the Japanese are most satisfied with everyone's ability to receive top-quality care and with personal waiting times for appointments. However, they consider minimizing personal health-care costs more important than respondents in other countries, which may be part of the reason for their apparent overall discontent: Satisfaction in this particular dimension is close to the bottom in Japan.

Concern with health costs in Japan extends beyond personal experience; a majority feel that too much money is spent on hospitalization, advanced technology and treating patients who are terminally ill. (Japan is the only country where a majority feels too much is being spent on the latter two categories.) A strong plurality also finds spending on physicians too high.

The Japanese are the most likely to feel they have been discouraged from seeking medical treatment. They are the least likely to feel that they have been unable to get all of the diagnostic tests they need.

PERCENTAGE OF POPULATION WITH PUBLIC COVERAGE:

100%: 52% through Health Insurance for Employees (HiE), 48% through National Health Insurance (NHI).

ELIGIBILITY:

HIE: all employees (employers with more than 700 employees may contract out of the government plan and establish an independent plan).

NHI: those not covered by HIE.

WHAT'S COVERED:

Hospital care: *HIE*—90% (employees), 80% (employees' dependents) (out-of-pocket maximum = $392/month).

NHI—70% (100% for elderly with $3/day copayment) (out-of-pocket maximum = $392/month).

Outpatient care: *HIE*—90% (employees), 70% (employees' dependents).

NHI—70% (100% for elderly with $6/month deductible).

Prescription drugs: *HIE*—90% (employees), 70% (employees' dependents).

NHI—70% (100% for elderly).

HOW FINANCED:

HIE: 4.15% payroll taxes on employers and employees, plus copayments.

NHI: 50% through federal taxes, some local government subsidies, plus income-adjusted premiums up to $2,543/year.

DELIVERY SYSTEM:

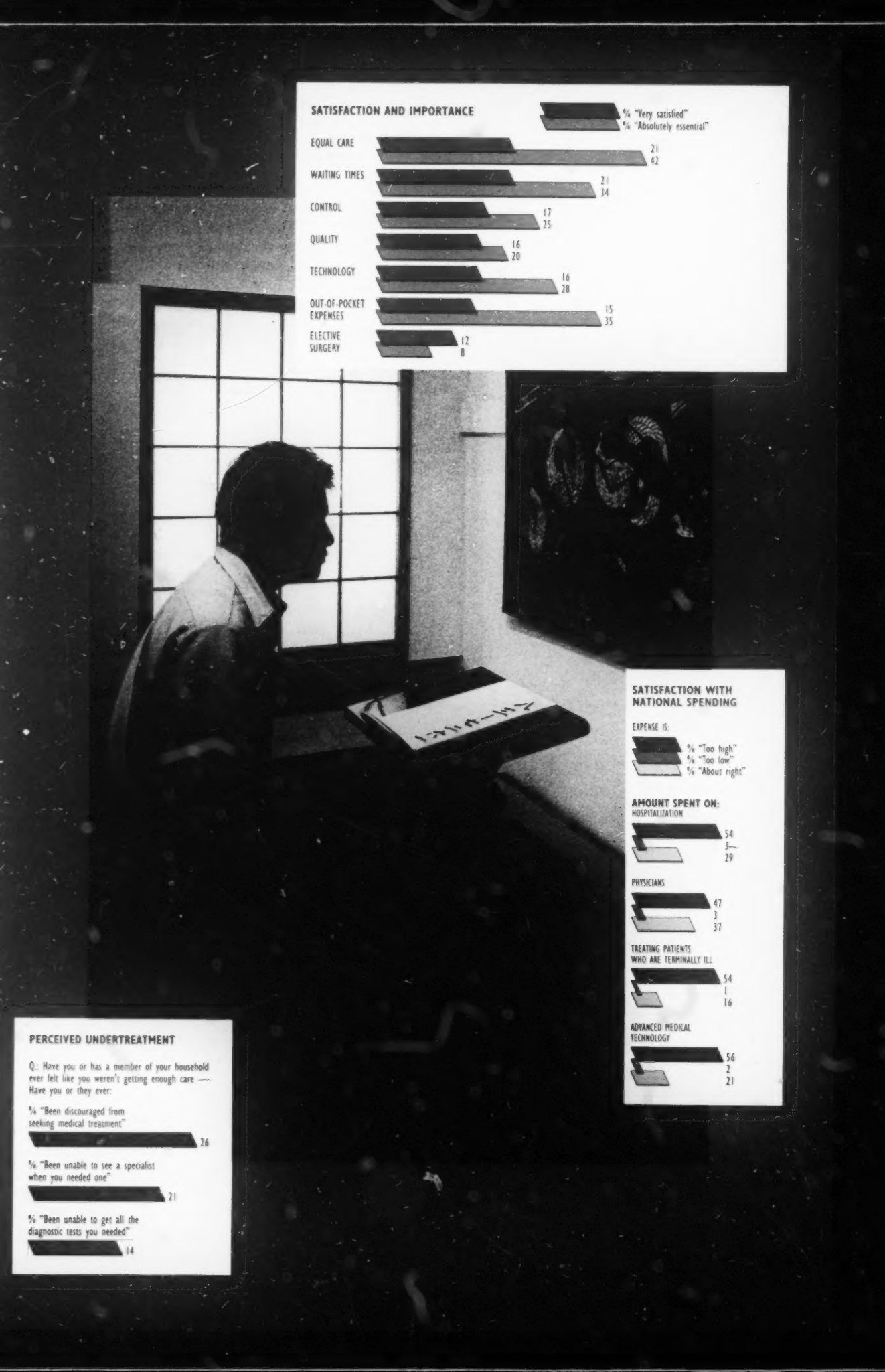
Physicians practice in clinics (with fewer than 20 beds), or hospitals (with 20 or more). Clinic physicians, who are paid negotiated and binding fees-for-service, are not permitted to care for hospitalized patients, where services are provided by salaried physicians.

PERCENTAGE OF POPULATION WITH PRIVATE COVERAGE:

0% (some supplemental benefits can be purchased through HIE).

NOTE:

Japan suffers from a duplication of services and equipment because of traditional and continuing political rivalries between clinic physicians and hospital-based physicians. Japanese patients tend to visit doctors frequently and have long lengths of stay in hospitals, including long-term care for the elderly.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16
20
TECHNOLOGY
16
28
OUT-OF-POCKET EXPENSES
15
35
ELECTIVE SURGERY
12
8
SATISFACTION WITH NATIONAL SPENDING
EXPENSE IS:
% "Too high"
% "Too low"
% "About right"
AMOUNT SPENT ON:
HOSPITALIZATION
54
3
29
PHYSICIANS
47
3
37
TREATING PATIENTS WHO ARE TERMINALLY ILL
54
1
16
ADVANCED MEDICAL TECHNOLOGY
56
2
21
PERCEIVED UNDERTREATMENT
Q.: Have you or has a member of your household ever felt like you weren't getting enough care — Have you or they ever:
% "Been discouraged from seeking medical treatment"
26
% "Been unable to see a specialist when you needed one"
21
% "Been unable to get all the diagnostic tests you needed"
14

SWEDEN

The Swedish health-care system achieves a level of customer satisfaction that is only slightly higher than the Japanese system and is significantly lower than that in any of the other countries tested.

Swedes account themselves most satisfied with receiving what they consider to be high-quality care and with their personal cost of care. They are least satisfied with the personal control they have over decisions affecting treatment.

Swedes rank the importance of the opportunity to receive top-quality care regardless of income higher than the populations of the other five countries surveyed: two-thirds of Swedish respondents said equal care was "absolutely essential." But only 29 percent are very satisfied by their country's success in providing it.

Notwithstanding these relatively low scores, Swedes are no more likely than other nationalities to feel they have personally been denied access to needed care. Moreover, the percentage who feel they have been discouraged from seeking medical treatment is by far the lowest among the six countries.

Swedes are most content among the six countries with the amount of money being spent on physicians, and Sweden ranks second behind Germany in the percentage of respondents who feel that spending levels are about right for hospitalization. A plurality believe this is true for all categories of spending.

PERCENTAGE OF POPULATION WITH PUBLIC COVERAGE:
100%.

ELIGIBILITY:
Automatic for all residents

WHAT'S COVERED:
Hospital care: 100% ($10 daily fee, up to $150/year maximum).
Outpatient care: 100% ($10 fee/visit, up to $150/year maximum).
Prescription drugs: 100% for "essential" drugs.

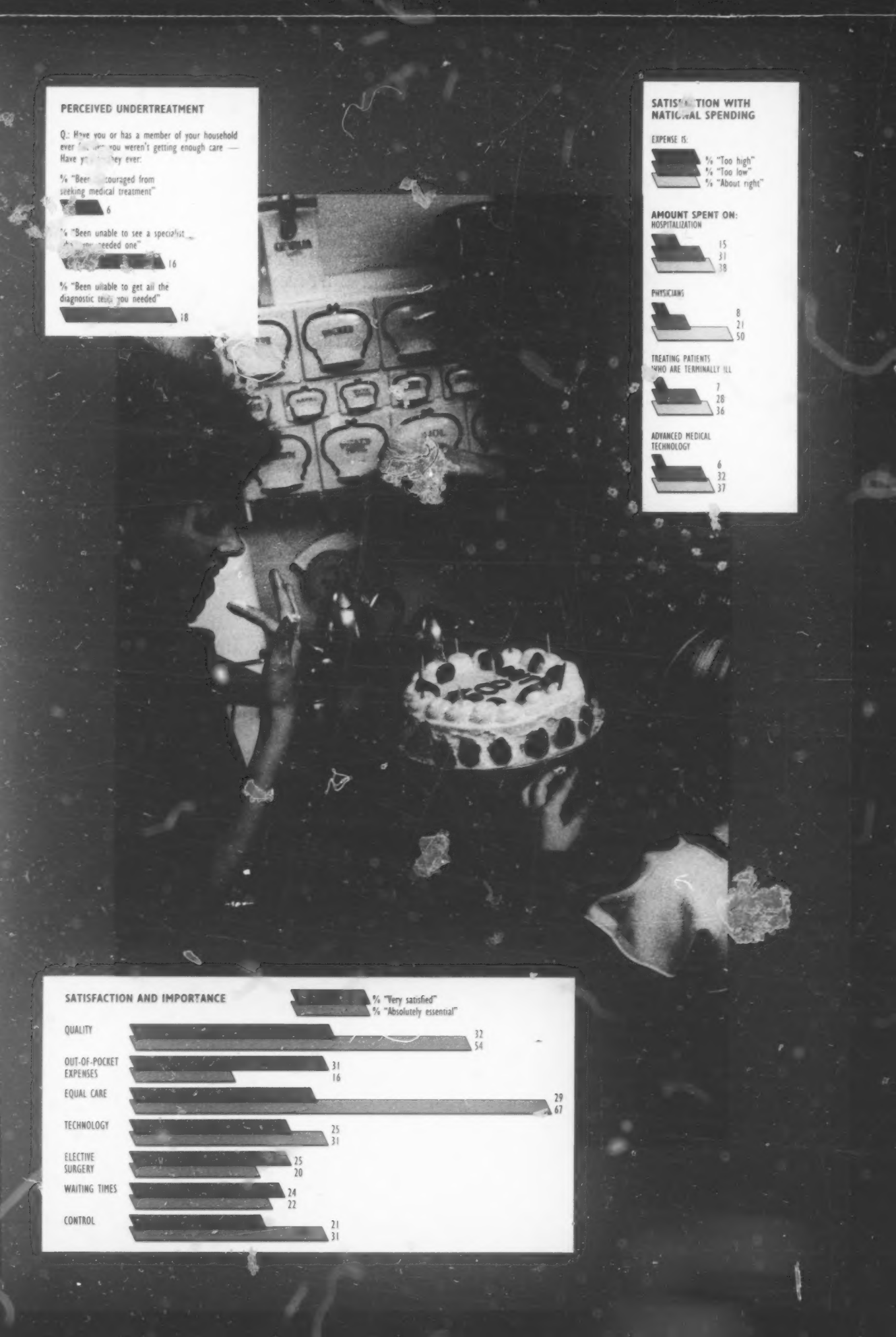
HOW FINANCED:
10% by employer payroll tax, 65% by local tax, 6.5% by federal tax, plus some government subsidies.

DELIVERY SYSTEM:
County councils employ salaried physicians and own and operate regional hospitals which have prospective annual budgets; most outpatient care is provided in regional primary-care centers, or "polyclinics."

PERCENTAGE OF POPULATION WITH PRIVATE COVERAGE:
7% have supplemental coverage.

SOURCE OF PRIVATE COVERAGE:
Employers.

NOTE:
Private supplemental insurance is most commonly reserved for business executives and their families, and covers such things as private hospital accommodations and privately provided nonemergency surgery, for which there would otherwise be long waiting periods.


PERCEIVED UNDERTREATMENT
Q.: Have you or has a member of your household ever felt that you weren't getting enough care — Have you or they ever:
% "Been discouraged from seeking medical treatment"
6
% "Been unable to see a specialist you needed one"
16
% "Been unable to get all the diagnostic tests you needed"
18
SATISFACTION WITH NATIONAL SPENDING
EXPENSE IS:
% "Too high"
% "Too low"
% "About right"
AMOUNT SPENT ON:
HOSPITALIZATION
15
31
38
PHYSICIANS
8
21
50
TREATING PATIENTS WHO ARE TERMINALLY ILL
7
28
36
ADVANCED MEDICAL TECHNOLOGY
6
32
37
SATISFACTION AND IMPORTANCE
% "Very satisfied"
% "Absolutely essential"
QUALITY
32
54
OUT-OF-POCKET EXPENSES
31
16
EQUAL CARE
29
67
TECHNOLOGY
25
31
ELECTIVE SURGERY
25
20
WAITING TIMES
24
22
CONTROL
21
31

UNITED STATES

Americans rank second only to Canadians in overall satisfaction with the health care available to them. They are especially satisfied with their access to advanced tests, drugs and procedures; personal control; receiving what they consider to be high-quality care; and not having to wait too long to see a doctor. They are more satisfied than citizens of the other five countries surveyed with every dimension of their health services except perceived quality, minimizing personal out-of-pocket costs and equal care; in each of these attributes, Canadians are more satisfied than Americans. While Americans rank the opportunity for everyone to receive top-quality care regardless of income first in importance, it is last in satisfaction.

More than seven Americans in ten feel that too much money is being spent on hospitals and physicians, a figure far higher than those for citizens of the five other countries.

Since the U.S. is the only country with an uninsured population, the Harris survey asked American respondents about the kind of insurance they have, if any. Not surprisingly, the survey found significantly lower levels of overall satisfaction among uninsured Americans (29 percent "very satisfied") than among insured Americans (57 percent "very satisfied").

PERCENTAGE OF POPULATION WITH COVERAGE:

65% private.
22% public (13% Medicare, 9% Medicaid).
13% uninsured.

ELIGIBILITY:

Private: Most but not all employers offer health insurance; individuals who meet the health criteria of the insurer can purchase insurance themselves.
Public: *Medicare*—Age 65 and over, and some disabled. *Medicaid*—Income at or below poverty level (varies by state).

WHAT'S COVERED:

Hospital care: *Private*—varies from 80% to 100%.
Medicare—100% for the first 60 days, after a $628 deductible; after 60 days patient pays fixed daily fees.
Medicaid—100%.
Outpatient care: *Private*—varies from 0% (for routine or preventive care) to 100% (often with copayments).
Medicare—80%, after a $100 annual deductible.
Medicaid—100%.
Prescription drugs: *Private*—varies from 0% to 100% (often with copayments).
Medicare—not covered.
Medicaid—100%.

HOW FINANCED:

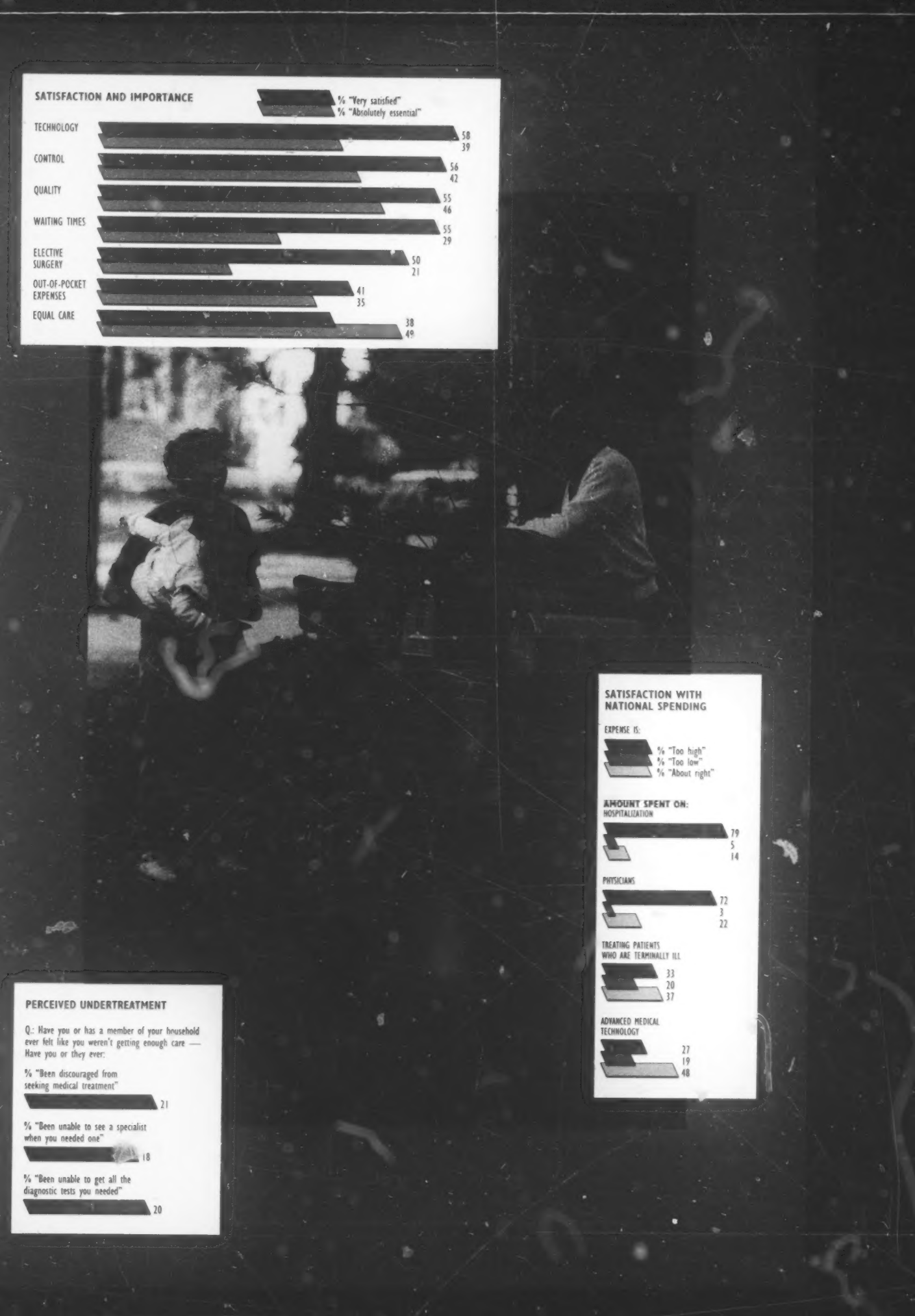
Private: employer and employee contributions (% varies); self-paying subscribers.
Public: *Medicare*—employer and employee payroll tax and general revenues. *Medicaid*—50% federal, 50% state taxes

DELIVERY SYSTEM:

Private physicians on fee-for-service basis; managed-care organizations (some with salaried physicians); public and private hospitals and clinics.

NOTE:

US physicians are unique in the autonomy with which they set their fees. With the exception of salaried HMO physicians, most are reimbursed by private insurance companies, Medicare and Medicaid, and, in many cases, may bill the patient the balance of the fee not paid by the primary payor. Public and private hospitals are subject to a variety of state and federal price regulations.


SATISFACTION AND IMPORTANCE
% "Very satisfied"
% "Absolutely essential"
TECHNOLOGY
58
39
CONTROL
56
42
QUALITY
55
46
WAITING TIMES
55
29
ELECTIVE SURGERY
50
21
OUT-OF-POCKET EXPENSES
41
35
EQUAL CARE
38
49
SATISFACTION WITH NATIONAL SPENDING
EXPENSE IS:
% "Too high"
% "Too low"
% "About right"
AMOUNT SPENT ON:
HOSPITALIZATION
79
5
14
PHYSICIANS
72
3
22
TREATING PATIENTS WHO ARE TERMINALLY ILL
33
20
37
ADVANCED MEDICAL TECHNOLOGY
27
19
48
PERCEIVED UNDERTREATMENT
Q.: Have you or has a member of your household ever felt like you weren't getting enough care — Have you or they ever:
% "Been discouraged from seeking medical treatment"
21
% "Been unable to see a specialist when you needed one"
18
% "Been unable to get all the diagnostic tests you needed"
20

OTHER COUNTRIES TO CONSIDER

The six countries surveyed by Louis Harris and Associates represent a cross section of industrialized nations for which other types of health-care data have been collected. There are other countries whose systems are worth examining as well, so we are including a sampling of spending and health measures data from Australia, France, Italy, the Netherlands and Switzerland.

	ANNUAL PER CAPITA HEALTH-CARE EXPENDITURE	HEALTH-CARE SPENDING AS % OF GDP	INFANT MORTALITY PER 1000 LIVE BIRTHS	LIFE EXPECTANCY
AUSTRALIA	$990	7.0%	8.2	76.6
FRANCE	$1178	8.7%	6.3	77.6
ITALY	$995	7.3%	6.1	78.0
NETHERLANDS	$1071	8.4%	7.0	77.6
SWITZERLAND	$1301	7.9%	4.9	78.9

THE LOUIS HARRIS SURVEY

The research by Louis Harris and Associates was funded by the Harvard Community Health Plan Foundation. The survey was conducted by telephone among representative cross sections of the adult population in each of the six countries between September 23 and October 24, 1990. The sample size for each country was from 1000 to 1026. Weighting was carried out by age, race, sex and education in the U.S. to conform the sample to parameters of the adult population. In other countries, weighting was carried out by age, sex, income or other demographic categories as appropriate.

For a copy of the complete survey, please send a $10 check or money order, made out to Harvard Community Health Plan, to HCHP Harris Survey, 10 Brookline Place West, Brookline, MA 02146.

SOURCES

Employee Benefit Research Institute, "Issue Brief" (no. 106, September 1990).

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A FAILING SYSTEM OF HEALTH CARE

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There are many ways to assess a health-care system. By almost any standard, ours is failing. We are denying access to many who are in need, and our system is expensive, inefficient and increasingly bureaucratic.

While some of the failings of U.S. health care are evident in the data presented in this annual report, many are not. The most serious one is our failure to guarantee access to care. Between 31 and 37 million Americans have no health insurance of any kind. An additional 20 to 50 million are underinsured—i.e. they have insurance with so many co-payments, deductibles, or exclusions that they would be bankrupted by a major illness. With only one percent of the population carrying private long-term-care insurance, virtually *any* American could be impoverished by a prolonged disabling illness.

The uninsured and underinsured find their health-care options markedly constricted. A recent survey found members of more than one million American families were denied care for financial reasons. Three hundred thousand people each year were turned away from hospital emergency rooms, occasionally with lethal results. And fifteen percent of people who had health insurance needed medical care they were unable to afford.

Our health statistics reflect this inadequate access to care. Our infant mortality rate is among the worst in the developed world, about twice that of Japan. Almost one third of our children are not adequately immunized, and average life expectancy is two and a half to three and a half years shorter than that in Japan, Sweden or Canada.

The international data presented in this report also makes clear our failure to set reasonable limits on health-care costs. Devoting well over 11 percent of our GNP to health care, we lead the world in health-care spending, with per capita costs nearly a third higher than Canada's. (Canada has the world's second highest per-capita health-care costs.)

Despite a reasonable level of satisfaction with the care we actually receive, Americans are troubled by the system's failings: its bureaucratization, its high costs, its poor health results and, most of all, its failure to guarantee health care to all Americans. It is time to fundamentally change the trajectory of American medicine, to adopt a universal, comprehensive, public system of paying for care. A national health program could remedy these failings and allow us to move on to confront other vexing problems. Which health services genuinely enhance the quality of life? How can we ameliorate the health toll of poverty, ignorance, stress, and addictions?

A national health program for the U.S. would provide the framework for facing the challenges ahead.

LESSONS FROM CANADA

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The polls say that no country is entirely happy with its health-care system—hardly a surprise, given the ubiquitous gulf between medical needs and medical services! Dissatisfactions will almost surely grow as medical capabilities, medical demands, and medical costs continue to increase. Therefore, every country is well advised to look at other countries for new models and lessons to learn.

Two problems in our health-care system most concern Americans—first, escalating costs and, second, the large fraction of our population, including children, who lack adequate health insurance. Because many fear that solutions to those two problems are mutually exclusive, it is encouraging to look at Canada's experience, which suggests otherwise.

For many years Canada's health costs relative to its GNP rose at a rate similar to ours, and its insurance coverage

remained incomplete. Then, in 1971 the Canadian federal government enacted legislation designed to make access to health care universal; comprehensive and portable insurance coverage became available to all Canadians, including those who were previously uncovered.

In the years since, to the surprise of many, the fraction of Canadian GNP spent for health care levelled off. All of this took place as tens of millions of U.S. citizens continued to be inadequately insured, and the fraction of our GNP spent in the health sector continued to grow.

Many aspects of the Canadian experience and their present arrangements therefore merit our attention. Three seem to me particularly relevant: First, health decisions, including those relative to resource allocation, are made at the level of the ten provincial governments. Second, in every province there is only one payor—the province itself. Third, there is strong and growing emphasis on primary care.

With respect to the site of health decisions, the federal government sets overall health policy and minimal standards for the nation—for example, that all residents must be provided with comprehensive insurance; in return for its compliance with federal standards, the province benefits from federal cost-sharing. But each province decides on its own how the system will function within its borders. Once a year, each provincial minister of health negotiates financial arrangements with hospitals, doctors, nurses, and other groups within the system. All capital expenditures are also allocated and provided by the provincial ministry. Thus, decisions that are crucial to setting local priorities rest with each province, and not with the federal government or individual institutions. As a result, in a given year, British Columbia, Quebec and Nova Scotia, for example, may each decide differently about the proportion of their resources that will be directed at the care of the elderly, children and the mentally ill, or neonatal intensive care units.

Second, Canada has a single-payor system; the province is the *only* major source of health-care revenue. This means that reimbursement for hospitalization and doctors' bills comes in whole from the province, and not, as in the United States, from a diverse collection of federal, state, municipal and private insurance, as well as individual sources. Since a hospital or doctor can submit all bills to just one office, the savings in administrative costs are enormous—Ontario says those costs now represent just four percent of its health budget, compared with 12 percent or more when multiple payors were involved. The single-payor arrangement can lead to even more savings than just those in administrative costs. The fee negotiated by the province for a heart operation, for example, is fixed for the entire year. Supplemental billing is illegal. Within a province variations in physician fees don't exist from one city to another, or one institution to another—variations that in our country often depend partly on who is paying.

Another virtue of the single-payor system is that it permits each province to implement the priorities it sets. Even if Massachusetts or Minnesota were to decide to put more money in child health and less in transplant surgery (or the reverse), the goal would be almost impossible to achieve unless it could enlist all payors to follow suit. That barrier does not exist in Saskatchewan or Manitoba.

Finally, many experts believe that a strong primary-care system is a prerequisite not only for good medical care, but also for efficient medical care. At least 53 percent of Canada's physicians are oriented to primary-care, and the remainder are specialists. In the United States, on the other hand, there are many more specialists than primary care doctors. This means that an American with a simple medical problem is more likely than a Canadian to be seen by a specialist and, perhaps, to be subjected to complex, expensive, and sometimes unnecessary procedures.

Has Canada achieved some of the health-care objectives toward which the United States strives? The answer is unquestionably, yes. Has it done so in ways that we would want to try? That question is much tougher to answer. Surely, our system has many important elements that we don't want to give up.

Could we somehow combine the best of ours and theirs? I think we could, but in making the effort we might well follow the Canadian example of approaching complicated problems on a level that is more limited than trying to set policy for the nation as a whole. In a country as large, heterogeneous and complicated as ours, we could develop pilot studies, as the Canadians have done repeatedly from one province to another. That leads to a final question: Which states will begin?

A HOME-GROWN APPROACH TO HEALTH-CARE REFORM

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Daniel D. Stid
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Appealing as it might appear, to adopt the Canadian health-care system in the U.S. would mean a sharp discontinuity with the past—an attempt, as it were, to jump off this world and onto another. Proponents of the Canadian model assume that sweeping change is a possibility, but the only political change of this sort in recent American history has been a marked *reduction* in the role and capacity of government (deregulation, the taxpayer revolt), not augmentation.

Proponents of the Canadian model for the U.S. don't explain how we would actually get there from here. The states do not begin to have the administrative capacity needed for such a task. The least implausible scenario would be to declare everyone covered by the federal Medicare program. But either way, a government takeover of health-care finance would require raising taxes and public expenditures by roughly $250 billion per year, a proposal not likely to win a majority vote in Congress. (Although much of this amount would represent a shift from private to public spending, it *would* require new government revenues.)

To adopt the Canadian system, furthermore, it would be necessary to overcome the determined opposition of some very well-financed and politically powerful groups: most doctors and hospitals, who would not want to accept government as sole payor (they already object that Medicare and Medicaid don't pay them enough); pharmaceutical companies and medical equipment manufacturers; insurance companies, HMOs, and other health-care financing organizations, which would be put out of business by such a government takeover. These would be no doubt joined by well-to-do, well-covered Americans, who would foresee their taxes being raised and their ready access to high-technology care threatened. (Indeed, middle-class elderly Americans recently beat back an attempt to extend catastrophic expense protection to *all* elders, because it would have meant higher taxes for them.)

The Canadian system works well in Canada because their political culture is profoundly different from ours. Seymour Martin Lipset traces the historical roots in his recent book *Continental Divide*: "Americans do not know but Canadians cannot forget that two nations, not one, came out of the American Revolution. The United States is the country of the revolution, Canada of the counterrevolution.... The very organizing principles that framed these nations...were different. One was Whig and classically liberal or libertarian—doctrines that emphasize distrust of the state, egalitarianism, and populism—reinforced by a voluntaristic and congregational religious tradition. The other was Tory and conservative in the British and European sense—accepting the need for a strong state, for respect for authority, for deference—and endorsed by hierarchically organized religions that supported and were supported by the state."

All this was summarized by Canada's Fathers of Confederation who chose the goals of "peace, order and good government," while our Founders fought for "life, liberty and the pursuit of happiness." Canadian political culture has produced and been reinforced by a particular set of political institutions—notably, a parliamentary system of government with party programs and party discipline that make politicians in power collectively responsible. Somebody *is* in charge up there.

Nobody is in charge down here, and hence nobody can be held responsible. We have a separate executive branch, a powerfully bicameral legislature, and an independent judiciary who constantly haggle over, check and balance their shared

powers; politicians who are re-election-minded entrepreneurs; and political parties that can neither discipline nor integrate these disparate individuals and institutions. After successfully rebelling against what our Founders considered to be an overly powerful and unjust government, they were determined that the new republic would not fall victim to any new tyranny. Thus, as Justice Brandeis noted, the primary purpose of our constitutional arrangements is "not to promote efficiency but to preclude the exercise of arbitrary power." While these have, for the most part, prevented the abuse of power, they have also made it difficult to plan, pass and implement a coherent legislative program.

Does this mean we can do nothing to reform our increasingly unsatisfactory health-care system? No. But it does suggest that any successful reform program must respect American cultural preferences for self-reliance, local decisions, private action, pluralism, multiple competing systems and individual choices. And it must take systematic account of the designed-in limitations of our unique form of government.

A more viable reform program (i.e., one that could be enacted incrementally and at a feasible cost) might be built on the movement to "managed care:" This would cover all Americans through either employment, Medicare or Medicaid, or new public agencies that would contract with several managed-care plans in each area and offer a subsidized choice of plans to the uninsured. It would limit the tax deductions employers may take for their contributions to employee health insurance, and use the savings to subsidize coverage for the uninsured. It would require all employers to cover full-time employees, and pay a payroll tax on the earnings of uninsured employees, the proceeds of which would be used to subsidize their coverage. It would restructure tax laws (which contain large subsidies for health-insurance purchases) and the Medicare program to require all people (except the poor) to make a cost-conscious choice of health-care plans. Finally, it would manage and inform this process of choice in such a way that health plans would be rewarded for producing better care at less cost, and not for selecting healthier patients.